Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005164	A. BUILDING: _____ B. WING _____	02/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHSOUTH DEACONESS REHABILITATION HOSI	4100 COVERT AVE EVANSVILLE, IN 47714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of one State complaint. Complaint #: IN00120661 Unsubstantiated: Lack of sufficient evidence. Facility #: 005164 Date: 2-4-13 Surveyor: Billie Jo Fritch RN, MBA, MSN Public Health Nurse Surveyor HealthSouth Deaconess Rehabilitation Hospital was found in compliance with 410 IAC 15-1.6.6, Rehabilitation services, Hospital Licensure Rules. QA: claughlin 02/08/13	S 000		